Creditors may rely upon the use of electronic communications or acknowledgments to satisfy requirements for delivery of disclosures, notices and other information through electronic communications provided that the consumer:

Expressly consents to online disclosures and/or acknowledgments and does so electronically; receives a description of the type of information to be provided electronically; receives an explanation of how to access and retain the online disclosures, including consideration of the consumer's ability to print or download such disclosures; and receives a notice of the period of time that the information will be available to the consumer in electronic form.

The legislation provides the appropriate regulator with the authority to prescribe regulations from time to time to clarify the procedures applicable to the delivery of electronic communications. The legislation further provides the appropriate regulator with the authority to prescribe, without affecting or impairing the legal effectiveness of the delivery of any electronic communication provided for in the Act, procedures which provide consumers with the option to request paper copies of any such communications if it finds that such procedures are necessary and appropriate to supplement electronic communications. The legislation would be effective upon date of enactment.

The legislation addresses only electronic delivery of information to consumers. It does not affect the substantive rights and responsibilities of any party or the content of any disclosure, including both the timing and format of disclosures and the information to be provided.

RECOGNIZING THE PLIGHT OF HOME HEALTH CARE AGENCIES

HON. J.C. WATTS, JR.

OF OKLAHOMA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 27, 1999

Mr. WATTS of Oklahoma. Mr. Speaker, there is a growing concern over the devastating situation that is plaguing Home Health Care Agencies in this country.

Today I am introducing the Medicare Home Health Services Equity Act of 1999 to provide greater equity to Medicare-certified home health agencies, and to ensure access to medicare beneficiaries to medically necessary home health services furnished in an efficient manner under the Medicare Program.

Quality, efficient home health care agencies are suffering under the punitive Interim Payment System and are going out of business. The per beneficiary limits imposed on home health agencies do not, for a great number of agencies, accurately reflect the costs necessarily incurred in the efficient delivery of needed home health services to beneficiaries.

The amount of reductions in reimbursement for home health services furnished under the Medicare program significantly exceeds the amount of reduction in reimbursement for any other service furnished under the Medicare program. This comes at a time when the need for home health services by the Nation's elderly citizens is growing.

Although this is a nation-wide problem, the impact on my home state of Oklahoma has been disproportionately high. In Oklahoma alone, 198 of the 381 licensed home health care agencies have been forced to close their doors, of which 146 were Medicare certified.

Surviving home health agencies which have managed to stay in business have curtailed their medical services due to financial constraints. As a result of this terrible tragedy, the sickest, most frail Medicare beneficiaries are being deprived access to medically necessary home health services. Thousands of elderly and disabled Americans are not receiving the type of quality care at home that they so much need and deserve.

In our efforts to end fraud and abuse, we must make certain that the benefits and much needed services of home health agencies are not lost. Home health care is the least expensive, most cost efficient provider of medical services for Medicare beneficiaries and must be preserved.

For that reason, I am introducing the Medicare Home Health Services Equity Act of 1999. It is critically important that we address this crisis promptly and pass this vital legislation.

ASSESSING HMO CURBS

HON. DOUG BEREUTER

OF NEBRASKA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 27, 1999

Mr. BEREUTER. Mr. Speaker, this Member highly commends to his colleagues the following portions of an editorial ''Assessing HMO Curbs,'' which appeared in the July 21, 1999, edition of the Omaha World-Herald.

[From the Omaha World-Herald, July 21, 1999]

ASSESSING HMO CURBS

A lot of hot air accompanies the debate over whether Congress ought to provide a ''bill of rights'' for people who obtain their health care from health maintenance organizations.

But one thing is reasonably clear. The debate so far has been less about health care than it has been about campaigning for election in 2000.

Democrats want to go into the election season with an excuse to portray Republican candidates as indifferent to the suffering of sick and injured people. The theme is part of a blue-print for restoring Democratic Party control of Congress.

Michael M. Weinstein, in The New York Times, took a calm look at the situation for his readers Sunday. ''The debate consisted largely of name-calling,'' he said, with Vice President Al Gore and House Democratic Leader Richard Gephardt calling the GOP plan a charade and a fraud, respectively, and GOP Sen. Phil Gramm of Texas accusing the Democrats of wanting to destroy HMOs by mandating expensive coverage that would drive costs into the stratosphere.

''But the partisanship obscures an important truth,'' Weinstein wrote. ''The substantive differences are narrower than they seem. Removed from the context of election-year politics, combatants on both sides concede they could find ways to give Americans protection from health-care plans that wrongly skimp on coverage.''

Republicans, said Weinstein, know that their bill would never get past President Clinton. They like the bill because it will help them wring campaign contributions out of HMOs and insurance companies.

Democrats, the Times writer said, privately concede that their bill overreaches. But it will make them even more popular with their generous long-time allies, the members of the Trial Attorneys Association. The Democratic bill would repeal a ban on lawsuits against HMOs, furthering the attorneys' goal of expanding the field for punitive damages.

Weinstein identifies four issues that he says should be relatively easy to compromise: A method by which patients and their physicians can appeal to medical authorities the denial of reimbursement by an HMO; a defintion of medical necessity; a modified right to sue for denial of service; and the question of whether the legislation would cover 160 million patients in state-regulated health plans as well as the 50 million in employer-sponsored plans not covered by state regulations.

Political partisanship is not an evil thing. Americans have been well-served by the clash of ideas between two political parties with different philosophical approaches to government. It is part of the system of checks and balances.

However, there are some things that should be obvious to members of both parties.

Patients and their physicians tend to overuse health care, driving up the cost. Sometimes they have no other choice. The Wall Street Journal reported yesterday that visits to emergency rooms, one of the most expensive forms of treatment, are up in some places where HMO treatment is not available at nights and on weekends. Some HMOs want the right to decline reimbursement for emergency room treatment. Is that reasonable? In a case of medical necessity, of course it is not.

HMOs, in attempting to drive the cost back down, have sometimes gone too far in denying care. Although determining the extent of the problem is difficult, it has caused physicians to recoil in horror at the damage done to patients who were sent home from a hospital prematurely or in other ways denied treatment.

Mandated coverage, such as a patient bill of rights, drives up costs, which are typically passed on to the buyers of the health-care coverage—the same businesses and patient groups that turned to HMOs to keep costs down. Policy-makers must not avoid the question of what would happen if costs were raised so high that more people, because of unaffordability, became uninsured. What would be the logic behind that?

The question is how to preserve the benefits of cost-cutting while minimizing its potential to hurt people. Reasonable people, including a handful of moderate Republicans, seem to be saying that a rational way exists to make the system more humane without sacrificing cost-control.

INTRODUCTION OF PATIENT ABUSE PREVENTION ACT OF 1999

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, July 27, 1999

Mr. STARK. Mr. Speaker, I am pleased to introduce the ''Patient Abuse Prevention Act of 1999'', which is being simultaneously introduced in the Senate by Senator HERBERT